

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town near Leonardtown MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 years  
 Hospital, institution, or street address where death occurred:  
13 years  
 How long in hospital or institution? 13 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St. Mary's  
 City or town near Leonardtown MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Mary E. Bowers

## 3.(b) Social Security Number

4. Sex F 5. Color or race Cauc 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Jan 1 - 1898  
 8. AGE: Years 47 Months 7 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Herrmannsville St. Mary's Co. MD  
 (Town, county, and state)

10. Usual occupation None

## 11. Industry or business

12. Name George W. Bowers  
 13. Birthplace St. Mary's Co.  
 14. Maiden name Mary E. Bowers  
 15. Birthplace St. Mary's Co.

16. Informant I do brother  
 Address Herrmannsville MD

17. Burial Date thereof Aug 31, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Zion Fair  
 Location Herrmannsville MD

18. Funeral director W. C. Mattingly Son  
 Address Leonardtown MD

19. SB 45 Caucasian  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 19 45 at 4:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 22 19 45 to Aug 28 19 45  
 and that I last saw him alive on in Aug 5 19 45

Immediate cause of death Epilepsy  
 DURATION 14 yrs

Due to Epileptic fit

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE AT Hermann  
 M. D. or other \_\_\_\_\_  
 Address Leonardtown MD Date signed Aug 30 - 45

NAVY AND MARINE CORPS DEPARTMENT OF THE NAVY

CERTIFICATE OF DEATH

RECEIVED

SEP 1 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

## CERTIFICATE OF DEATH

08264

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Leonardtown Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Leonardtown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph Louis Edwards Jr

## 3. (b) Social Security Number

212-20-21074. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) April 13 1923 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 20 Months 4 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Leonardtown, Md.  
(Town, county, and state)10. Usual occupation Fireman

## 11. Industry or business

12. Name J. Louis Edwards13. Birthplace Leonardtown Md14. Maiden name Sindie Davis Edwards15. Birthplace Chaptico Md16. Informant J. Louis Edwards SrAddress Leonardtown Md17. Burial Date thereof Aug 28-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Clovis CemeteryLocation Leonardtown Md18. Funeral director W. C. Matney & SonAddress Leonardtown Md19. 5/28/45 19. 45 Cummins  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 19. 45 of 2:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 19. 45 to Aug 26 19. 45and that I last saw him Aug 26 19. 45

Immediate cause of death \_\_\_\_\_

Fracture of skull

Due to \_\_\_\_\_

Auto accident

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident suicide or homicide Date of 8/26/45Where did injury occur M. Leonardtown St Mary's and (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public RoadMeans of injury Auto accident Injured at work? No23. SIGNATURE Frank A. Cummins acting as D. or otherAddress Leonardtown Md Date signed 8/28/45

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
AUG 30 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 682

## CERTIFICATE OF DEATH

Reg. Dist. No. 08265 286

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Rural elements  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Louise Maria Hemmick

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife James Therman8. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) 5-18-428. AGE: Years 53 Months 3 Days 14 If less than one day hrs. min.9. Birthplace Elements Md  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Joseph Miles13. Birthplace Elements14. Maiden name Maria Miles15. Birthplace Elements16. Informant James T. HemmickAddress Elements Md17. Burial Date thereof 8-21-43  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Joseph'sLocation Worship18. Funeral director P. B. RobinsonAddress Laadth...19. 8-24-43 19 43 N. V. Palmer  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Mary'sCity or town Rural elements  
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23-1943 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-22-1944 to 8-23-1943and that I last saw him alive on 8-22-1943Immediate cause of death CerebralhypertensionDue to arteriosclerosisDue to hypertensionOther conditions General debilityMajor findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of 

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. PalmerAddress Laadth... Date signed 8-24-43

RECEIVED  
AUG 25 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Near Leonardtown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary'sCity or town Near Leonardtown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

4. Sex

Male

5. Color of face

Col.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

unknown

8. AGE:

Years

Months

Days

If less than one day

52

hrs.

min.

9. Birthplace

Perry S.C.  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden name

Unknown

15. Birthplace

18. Informant

Address

17. Burial  
(Burial, cremation, or removal, Which?)

Date thereof

8/11/45  
(month) (day) (year)

Cemetery or crematory

St. James

Location

18. Funeral director

Address

19. 8/11  
(Date rec'd by registrar)19. 45

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 10/45 19 45 4:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

saw him die on Aug 10/45 19 45

and that I last saw him \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death

Pulmonary Hemorrhage

DURATION

Due to

Emphysema

Due to

Sylliosis Heart History 6 mos

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. G. Greenwell  
M. D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED  
AUG 14 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

08267

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Chesapeake Bay ( Park Hall )  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Irving

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 2209 Penn. Ave. N.W.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Anna Irving6. (c) If alive, give age 51 years

## 7. Birth date of

deceased (mo., day, yr.)

July 23 1890

## 8. AGE:

Years

Months

Days

If less than one day

55

hrs. min.

## 9. Birthplace

Minnesota

(Town, county, and state)

## 10. Usual occupation

Rooming house operator

## 11. Industry or business

FATHER

## 12. Name

John Irving

## 13. Birthplace

Canada

MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

Unknown

## 16. Informant

Anna Irving

## Address

2209 Penn. Ave. N.W? Wash. D.C

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Aug. 11 /45

(month) (day) (year)

## Cemetery or crematory

Cedar Hill

## Location

Washington, D.C.

## 18. Funeral director

Joseph Gawlers, Sons, Inc.

## Address

Washington, D.C.

## 19. (Date rec'd by registrar)

8/10 45

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7th 19 45 at 7:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug-9-45 19 45 to Aug-7-45 19 45and that I last saw him alive on 19 45

Immediate cause of death

Drowning

DURATION

Due to

Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

F. F. Greenwell  
Surgeon  
 M. D. or otherAddress Surgeon Date signed Aug 10-45

EXHIBIT TO THE PROCEEDINGS OF THE CHANCERY

RETURN TO THE CHANCERY

RECEIVED  
AUG 11 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

## CERTIFICATE OF DEATH

Reg. Dlat. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Leonardtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 hrs  
 Hospital, institution, or street address where death occurred:  
St. Mary's Hospital  
 How long in hospital or institution? 15 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary's  
 City or town Leonardtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Infant Isobel

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced —

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 19/45 6. (c) If alive, give age — years8. AGE: Years Months Days If less than one day 15 hrs. min.9. Birthplace MD (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Elouis Isobel13. Birthplace Ala14. Maiden name Queen Mary Morgan15. Birthplace MD16. Informant Elouis IsobelAddress 745 Pat. Patient Room No. 117. (Burial, cremation, or removal. Which?) Burial Date thereof 8/20/45 (month) (day) (year)Cemetery or crematory St. Joseph'sLocation Maryland18. Funeral director Elouis IsobelAddress 745 Pat. Patient Room No. 119. 8/20 1945 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1945 12:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1945 to Aug 20 1945 and that I last saw him alive on Aug 19 1945Immediate cause of death Prematurity (6 wks) DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank A. Cameron M. D. or otherAddress Leonardtown Date signed 8/20/45

STATE OF NEW YORK STATE CHIEF OF CLERK

STATE OF NEW YORK

RECEIVED

AUG 22 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

## CERTIFICATE OF DEATH

08269

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Leonardtwn, Md (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 3445 Ordway St. N.W.  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Mary Helen MacWilliams

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>female</u>	<u>white</u>	<u>single</u>

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 19, 1927

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

18

hrs.

min.

9. Birthplace Washington, D.C.

(Town, county, and state)

10. Usual occupation Secretary

11. Industry or business

12. Name James R. MacWilliams13. Birthplace Washington, D.C.14. Maiden name Grace Mae O'Conner15. Birthplace Washington, D.C.16. Informant James R. MacWilliamsAddress Washington, D.C.17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 8/26/45  
 (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.18. Funeral director P.B. RobinsonAddress Leonardtwn, Md.19. 8/26 45  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1945, at 2:30 AM21. I CERTIFY that death occurred on the date above stated; that deceased deceased fromAug 26 1945, toand that I last saw h alive onImmediate cause of death Crushed Skull

DURATION

Due to Auto accident

Due to

Other conditions Multiple lacerations & contusions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/26/45Where did injury occur? In Leonardtown, D.C. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public RoadMeans of Injury Auto accident Injured at work? No23. SIGNATURE Frank A. CammillerAddress Leonardtwn, Md. Date signed 8/26/45

CERTIFICATE OF DEATH

STATE OF MARYLAND

COUNTY OF \_\_\_\_\_

TOWNSHIP OF \_\_\_\_\_

WARD OF \_\_\_\_\_

PREDECESSOR OF \_\_\_\_\_

DECEASED \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

Cause of Death \_\_\_\_\_

Immediate Cause \_\_\_\_\_

Underlying Cause \_\_\_\_\_

Contributing Cause \_\_\_\_\_

Mode of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Time of Death \_\_\_\_\_

Age at Death \_\_\_\_\_

Sex \_\_\_\_\_

Color \_\_\_\_\_

Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Education \_\_\_\_\_

Religion \_\_\_\_\_

Signature \_\_\_\_\_

Witness \_\_\_\_\_

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

## CERTIFICATE OF DEATH

08270

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's CountyCity or town NAS Patuxent River, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 hours 40 min.

Hospital, institution, or street address where death occurred:

Dispensary, Naval Air Station, Patuxent River, Md.How long in hospital or institution? 6 hrs 40 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town US NAS Patuxent River, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Quarters G  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MATTER, Dirk Meindert te Groen

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 21 August 1945

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

6 hrs. 40 min.9. Birthplace US NAS Patuxent River, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Matter, Alfred Richard, Comdr. USN13. Birthplace Butte, Montana14. Maiden name Parks, Elizabeth Evan15. Birthplace Wilmington, Delaware16. Informant Mrs. Alfred MatterAddress NAS Patuxent River, Md. Quarters G17. Cremated Date thereof 8/21/45  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory J. Wm Lee & SonsLocation Washington D.C.18. Funeral director P. B. RobinsonAddress Leonardtown, Md.19. 8/21/45 Canadier  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 21 August 19 45 at 12:10p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 August 19 45 to 21 August 19 45and that I last saw him alive on 21 August 19 45

Immediate cause of death

Asphyxia

DURATION

Lived6 hrs40 min.Due to Prematurity

Due to

Other conditions wt. 1 lb. 14 1/2 oz.length 13 3/8 in.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury E. G. Hamilton Injured at work?23. SIGNATURE E. G. HAMILTON, M.D., Lt. (MC) USNR

M. D. or other

Address NAS Patuxent River, Md. Date signed 8-21-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED  
AUG 24 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH

County St Mary's  
 City or town Holly Wood Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Mary's  
 City or town Holly Wood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Frederick A Norris

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced WidowedB. (b) Name of husband or wife 18727. Birth date of deceased (mo., day, yr.) B. (c) If alive, give age 73 years8. AGE: Years 73 Months Days If less than one day hrs. min.8. Birthplace Holly Wood St Mary's Co Md  
(town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Richard C. Norris13. Birthplace St Mary's Co14. Maiden name Irene Abell15. Birthplace St Mary's Co16. Informant Fred NorrisAddress Holly Wood Md17. Burial Date thereof Aug 31, 1945  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory St John CemeteryLocation Holly Wood Md18. Funeral director W C Mattingly SonsAddress Leonardtown Md19. 830 / 45 Cremation  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945 at 11:15 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28 45 to Aug 29 45and that I last saw him alive on Aug 28 1945Immediate cause of death Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bank N. Cacchialis

M. D. or other

Address Leonardtown MdDate signed 8/30/45

CERTIFICATE OF DEATH

RECEIVED  
SEP 1 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12-0

08272

## CERTIFICATE OF DEATH



Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County..... St Marys  
 City or town..... near Leonardtown Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 70 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St Marys  
 City or town..... near Leonardtown Md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... Rt 70 #1  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Jeannette D Peacock

## 3. (b) Social Security Number

4. Sex..... F 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... married

6.(b) Name of husband or wife..... George F. Peacock

7. Birth date of deceased (mo., day, yr.)..... March 4 - 1870

8. (c) If alive, give age..... 71 years

8. AGE: Years..... 75 Months..... 5 Days..... 15 If less than one day..... hrs. .... min.

9. Birthplace..... Charlotte Hall St Marys Md  
 (Town, county, and state)

10. Usual occupation..... House wife

11. Industry or business..... same

12. Name..... F. H. Bond

13. Birthplace..... St Marys Co

14. Maiden name..... Mary Curry

15. Birthplace..... St Marys Co

16. Informant..... George F. Peacock

Address..... Leonardtown Md

17. Burial..... St Johns Cemetery

Location..... Holly wood Md

18. Funeral director..... W C Mattingly Sr

Address..... Leonardtown Md

19. 723 CS Census

(Date rec'd by registrar)..... 19 CS Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 21 19 45 at..... 136 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... April 19 40 to..... Aug 21 19 45

and that I last saw him alive on..... Aug 21 19 45

Immediate cause of death.....

Inanition

Emphysema (Chronic)

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J F Greenwell

Address..... Leonardtown Md Date signed..... Aug 22 45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
AUG 25 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

## CERTIFICATE OF DEATH

08273

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's CountyCity or town US NAS Patuxent River, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:

Dispensary, US NAS Patuxent River, Md.How long in hospital or institution? 3 hrs 45 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia CountyCity or town Norfolk  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1507 Omohundro Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war World War II ✓

## 3. (a) FULL NAME

SHROYER, Keith Francis

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mrs. Mildred Shroyer7. Birth date of deceased (mo., day, yr.) March 10, 1908 6.(c) If alive, give age years8. AGE: Years 37 Months 5 Days 13 If less than one day hrs. min.9. Birthplace Colorado  
(Town, county, and state)10. Usual occupation CSSM(B)11. Industry or business U.S. NavyFATHER 12. Name Frank Shroyer13. Birthplace Exley, Col.MOTHER 14. Maiden name Edith Wailes Shroyer15. Birthplace Exley, Col.

16. Informant Address

17. Removal Date thereof 8/24/45  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Norfolk Va.Location Robinson Funeral Home, Leonard-

town, Md. for shipment to Francis

Address A. Gay Fun. Home, S. Norfolk, Va.19. 8/24 45 General  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 August 19 45 at 4.10a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 August 19 45 to 23 August 19 45 and that I last saw him alive on 23 August 19 45Immediate cause of death Fracture, compound, skullDue to Approximately 20 feet  
free fall, striking paving  
Due to below with skull.Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Compound, comminuted fracture, skull  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-23-45Where did injury occur? NAS Patuxent River, Md. St. Mary's  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) NAS Patuxent River, Md.Means of injury Fall Injured at work? NOSignature John R. Bruno23. SIGNATURE JOHN R. BRUNO, Lt. (MC) USN  
M. D. or otherAddress NAS Patuxent River, Md. Date signed 8-23-45

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
AUG 25 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

08274

## 1. PLACE OF DEATH

County St Marys  
 City or town Piney Point Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys  
 City or town Piney Point Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Benj Gorman Swann

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Anita G. Swann  
 7. Birth date of deceased (mo., day, yr.) Nov 5 - 1889 8.(c) If alive, give age 56 years  
 8. AGE: Years 55 Months 9 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1945 at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1944 to August 22 1945  
 and that I last saw him alive on August 22 1945

Immediate cause of death Carcinoma of Stomach DURATION 10 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Carcinoma of Stomach  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. X. Thompson M. D. or other \_\_\_\_\_Address Dryden Date signed 8/22/45

9. Birthplace Piney Point St Marys Md  
 (Town, county, and state)  
 10. Usual occupation merchant  
 11. Industry or business same  
 FATHER 12. Name James Thomas Swann  
 13. Birthplace St Marys Co  
 MOTHER 14. Maiden name Alice Mattingly  
 15. Birthplace St Marys Co  
 16. Informant Mrs Anita G. Swann  
 Address Piney Point Md  
 17. Burial Date thereof Aug 24 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St George Cemetery  
 Location Valley Lee Md  
 18. Funeral director W C Mattingly  
 Address Georgetown Md  
 19. 823 HS Registrar Canavan  
 (Date rec'd by registrar)

RECEIVED  
AUG 25 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

## CERTIFICATE OF DEATH

08275

Reg. Dist. No. *for*

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. 8/22/45

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 21

19. 45 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 10 19. 45 to Aug 21 19. 45

and that I last saw him alive on Aug 20 19. 45

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

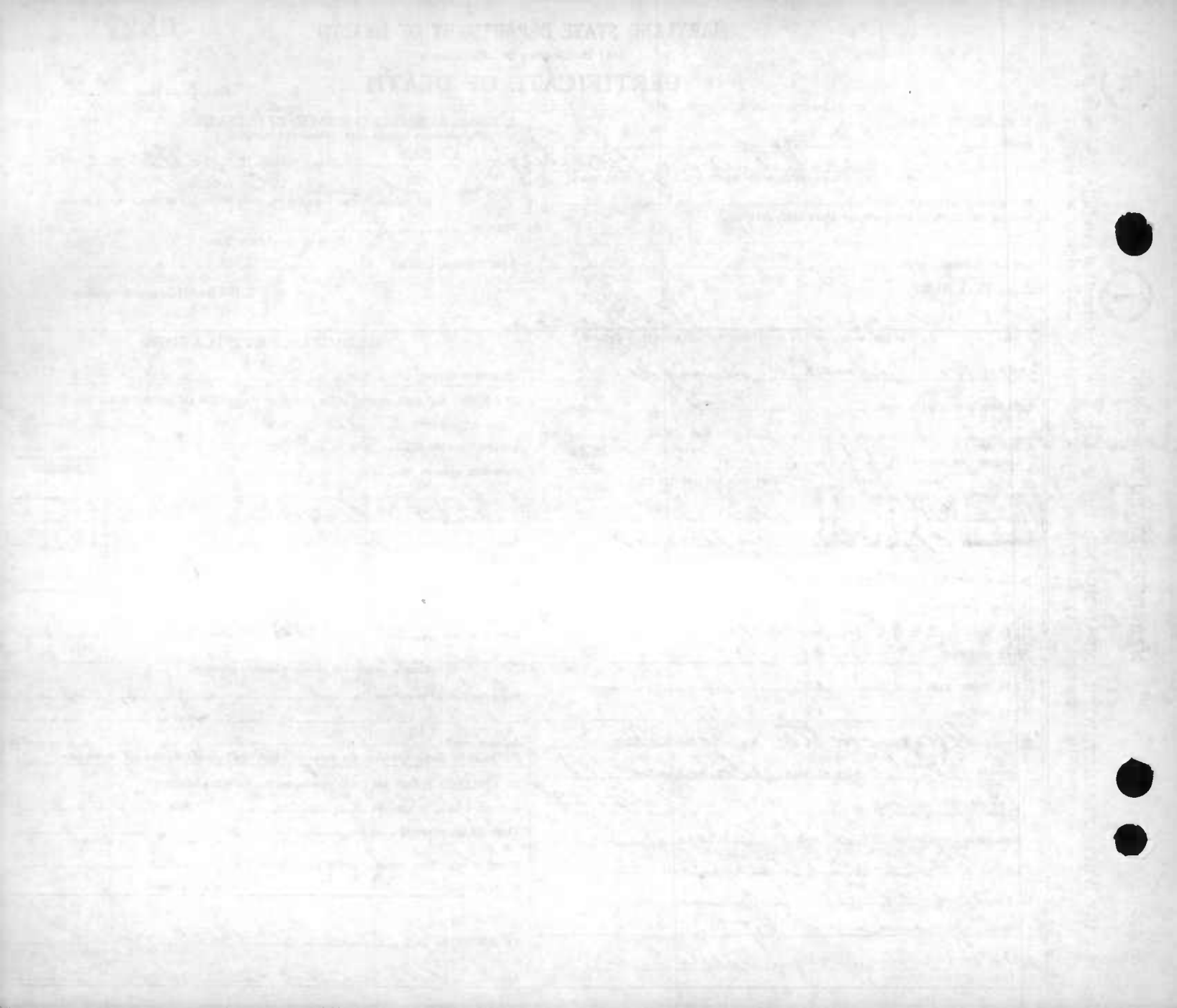
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 110-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 08276 286

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Rural at Bushwood and  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary's  
 City or town Rural at Bushwood and  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Henry Green  
 4. Sex m 5. Color or race wh 6. (a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 4-8-1881

8. AGE: Years Months Days If less than one day  
64 4 16 \_\_\_\_\_ hrs. \_\_\_\_\_ mo.

9. Birthplace Bushwood and  
 (Town, county, and state)

10. Usual occupation Farmer

## 11. Industry or business

12. Name John Henry Green13. Birthplace MD14. Maiden name Harriet Butler15. Birthplace Bushwood and16. Informant John Clement - SonAddress Bushwood and17. Burial Date thereof 5-27-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred HeartLocation Bushwood and18. Funeral director M. E. Mattingly SonAddress Frederick and19. 8-24-1945 R. V. Palmer

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24-1945 at 5 a M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-24-1945 to 8-24-1945and that I last saw him alive on 8-23-1945Immediate cause of death acute Bm

DURATION

3 wksDue to Pneumonia 2 wksDue to Bm complicated by 4 yrsOther conditions Sen. debility

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert V. Palmer

M. D. or other

Address Frederick and Date signed 8-24-45

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Place of death

RECEIVED

AUG 28 1945

BUREAU V.B.